National Hospital Insurance in Canada

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JULY 1, 1959, marked the first anniversary of national hospital insurance in Canada. It is too early yet to evaluate the new Canadian program in terms of experience, since only half of the 10 Provinces have participated for the full year, and data on costs, utilization, and other matters of interest are not yet available. It is an appropriate time, however, to survey some structural details of the new program. With respect to the financing of hospital care, as in many other areas, Canada has evolved what is essentially a middle way between American and British practice. The hospital insurance system now emerging in Canada is sufficiently different from our own—and in a general social, economic, and political setting sufficiently similar—to merit close interest in the United States.

The background of the Canadian hospital insurance program and the history of events that led up to it have been adequately described elsewhere (*1*,*2*). This report will sketch briefly the outlines of the national program, and then describe in greater detail some aspects which may be of particular interest to those concerned with health and medical care planning in this country. The report is based partly on published material, partly on conversations with officials of the Department of National Health and Welfare in Ottawa and other persons in the Canadian health field.

The Federal Act

The Hospital Insurance and Diagnostic Services Act, authorizing "contributions by Canada in respect of programmes administered by the Provinces providing hospital insurance and laboratory and other services in aid of diagnosis" (*3*), was enacted by unanimous vote of the Canadian Parliament more than 2 years ago. Its effectuation was delayed by a requirement that a majority of the 10 Provinces, having among them at least 50 percent of Canada's total population, be ready to participate. This requirement was eventually deleted, and the program commenced on July 1, 1958. The deletion was made in order to get the program started without waiting for Ontario. This province, with almost one-third of Canada's population, was by then fully committed, although its plan was not due to start until January 1959.

The act provides for a Federal contribution of approximately 50 percent of the costs of Provincial hospital insurance plans. The plans must provide certain benefits and meet certain conditions laid down in the act, but otherwise are entirely Provincial responsibilities. Details of participating plans are drawn up in written contractual agreements between Federal and Provincial governments, an arrangement constitutionally in accord with the British North American Act of 1867 (Canada's written constitution), which makes health and welfare specifically a Provincial responsibility.

Inpatient hospital benefits that must be provided by participating Provincial plans include:

- Ward-level accommodation and meals for as long as the physician considers them medically necessary.
- Necessary nursing services.

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• Diagnostic procedures together with necessary interpretations, including laboratory and radiological tests (but excluding clinical procedures related to diagnosis, which are considered medical rather than hospital services).

• Operating room, case room, anesthetic facilities, and such items as routine surgical supplies.

• Drugs, biologicals, and related preparations used in the hospital, as prescribed by the physician.

• Radiotherapy and physiotherapy where available.

• Services of salaried hospital personnel, excluding physicians giving medical and surgical care to individual patients, but including services provided by interns, residents, medical administrators, physiotherapists, radiotherapy technicians, occupational therapists, and social workers employed by the hospital.

Optional services which the Province may include as part of its hospital plan are:

• Rehabilitation and cancer programs.

• All or some of the above inpatient services on an outpatient basis.

An important condition for Provincial participation is that all these benefits, required or optional, must be available to all residents of the Province upon "uniform terms and conditions" (*3*), without restrictions, for example, as to age or income. This does not necessarily mean that coverage must be compulsory for all residents, although in fact most Provinces have chosen to make it so. Residency in the Province is defined to apply to everyone who makes a home there, including U.S. citizens, "new Canadians" (new immigrants), and other foreign citizens. Tourists and transients are excluded.

It must be stressed that these benefits cover only basic hospital care, and do not cover medical and surgical services provided in hospitals by physicians (including anesthetists), except insofar as provided by salaried hospital personnel, as mentioned earlier. If the patient wants accommodation above that provided at the basic level, for example, a private room, he must pay the extra cost. Mental and tuberculosis hospitals do not come under the program, nor do nursing homes, although patients in these institutions are eligible for transfer to general hospitals for insured hospital care if deemed medically necessary.

The Federal Contribution

The act, as well as specifying minimum requirements of participating Provincial plans, sets out the formula which determines the Federal share of the cost of the Provincial plan. This formula is related to hospital costs in the Provinces rather than to fiscal capacity or need.

The Federal contribution to the cost of each Provincial plan is 25 percent of the per capita cost of inpatient services in the Province plus 25 percent of the per capita cost of inpatient services in Canada as a whole, multiplied in each case by the average number of insured persons. The Federal contribution to all Provincial plans is thus approximately 50 percent of cost, although for individual Provinces it will vary from about 45 percent in high-cost Provinces such as Ontario to about 72 percent in low-cost Provinces such as Newfoundland. The costs of outpatient services, where provided, are shared in the same proportion as those of inpatient services. Monthly advances are made to the Provinces pending final calculation of these figures at the year's end.

To give an example of how this grant formula works, the average per capita cost of inpatient services for Newfoundland in 1959 is currently estimated by the Department of National Health and Welfare at $17.17, and for Canada at $24.84. (Details of how these figures are computed will be examined later.) Newfoundland then receives 25 percent of its per capita cost, or $4.29, plus 25 percent of Canadian per capita cost, or $6.21, making a Federal contribution to Newfoundland for inpatient services of $10.50 per person. Ontario, whose per capita cost is estimated at $26.60, would receive $6.65 plus $6.21, totaling $12.86—a larger absolute amount per capita, but a smaller proportion of total cost per capita.

Since the Provinces with the lowest per capita hospital costs are also the poorest, this formula does tend in fact to give greatest assistance to those with the lowest fiscal capacity. The formula is designed, however, to exert an equalizing influence on hospital standards

Note on Federal Aid to Health Programs in Canada

While Canada, particularly in the postwar years, has placed growing emphasis on unconditional fiscal aid to the Provincial governments, the conditional grant programs have not been neglected. They have covered a wide range with heavy emphasis on health and welfare.

The relative importance of conditional and unconditional grants has been sharply altered, however, with the coming into effect of hospital insurance in July 1958. With only six Provinces participating in the first year, the Federal cost in fiscal year 1959 should not exceed $70 million. With all Provinces in, the cost will rise to about $200 million. Total conditional grant payments have not much exceeded $100 million in any year since the old age security payments became a sole Dominion responsibility in 1952.

In all its conditional grant programs, Canada has resisted the arguments in favor of fiscal need differentials in the scale of payments to the various Provinces. This was not because the Provinces do not differ widely in their relative wealth. They do, indeed. Personal income per person varies from $768 in Prince Edward Island to $1,676 in Ontario, with a national average of $1,395. Rather, it was because in recent years these programs had developed alongside the general unconditional fiscal aid arrangements, which, it was felt, made a fiscal aid factor in the conditional grant programs superfluous.

This unconditional assistance has increased substantially from year to year, but nevertheless it could be said with good reason that these special programs laid a heavier proportionate burden on the revenues of the poorer Provinces, sometimes with budgetary side effects in the relative emphasis accorded different services.

The problem was further complicated with the hospital insurance program by its very size, which made the relationship to the scale of unconditional aid rather tenuous, and by the fact that standards of facilities and services differed widely from Province to Province. These widely different standards were not considered in keeping with a truly national scheme, and some additional incentive to improvement was required. Further, it was realized the scheme would never get off the ground in the poorer areas without a special stimulus. The situation was modified substantially by the expectation, based on experience, that costs would tend to even out as facilities were developed. Any large cost differential was considered likely to be of fairly limited duration.

The method devised to meet the situation was unique, at least in Canada's experience. The Federal share was to be 50 percent of the accepted cost. To meet the special regional problems it was decided to pay each Province 25 percent of the average per capita cost of hospital services in Canada as a whole plus 25 percent of the average per capita cost in each Province, multiplied by that portion of the Provincial population eligible under the particular scheme.

Thus, although the Federal cost is 50 percent for Canada as a whole, it is more than 70 percent in the poorest Province with lowest costs and between 45 and 50 percent in wealthier areas with well-developed services.

The contribution of this distribution to the fiscal well-being of the Provinces is secondary. The real test will be whether it is successful in raising standards of care in the less-favored Provinces of the federation, as would seem proper in a scheme that it essentially national.—R. M. BURNS, *Director, Federal-Provincial Relations Division, Department of Finance, Ottawa.*

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rather than to equalize hospital costs as such. A poor Province such as Newfoundland, which now has nearly three-quarters of the cost of its plan paid by the Federal Treasury in Ottawa, will be enabled to raise salaries and improve standards in its hospitals. As it does so, the per capita cost of hospital service under the Provincial plan will rise and the proportionate contribution of the Federal Government will fall.

There are no limits on the size of the Federal contribution. This exerts economic pressure upon the Provinces to increase the scope of their hospital plans by including services optional under the Federal act, such as outpatient service and rehabilitation programs.

As far as the Provincial authority is concerned, these services may be added to the plan at half cost, since the other half is paid by Ottawa. It is hoped that, as facilities become available, this pressure will induce all Provinces to provide the maximum range of services allowed under the act.

The maximum cost of the program to the Federal Government, with all Provinces participating, has been estimated at $215 million per year at current prices (*4*). Provincial governments collectively would provide an equal amount, making the maximum total cost of the program $430 million, or about 1.3 percent of the Canadian gross national product. An equivalent figure with regard to the U.S. economy at the present time would be in the region of $6 billion. Very little of the program cost represents new cost to the economy: it represents rather a consolidation of the expenditures for hospital service formerly made by individuals (either directly or indirectly through insurance), charitable groups, and all levels of government under a number of smaller programs.

The Federal Government finances its share from consolidated revenue; there is no special Federal tax for the hospital insurance program.

The Provincial Agreements

Thus far, only Quebec has failed to take advantage of the new program. Two Provinces, British Columbia and Saskatchewan, have had compulsory hospital insurance plans for some years, and these came into the national program substantially unchanged. Manitoba, Alberta, and Newfoundland commenced their plans on the effective date of the act. The last two of these previously had partial hospital plans—a municipal hospital program in Alberta and the Cottage Hospital program in Newfoundland—which have been incorporated in the new arrangements. Ontario and Nova Scotia started their plans on January 1, 1959, and New Brunswick on July 1, 1959. The remaining Province, Prince Edward Island, is expected to have an operative plan by the end of the year. Plans for the two Federally governed Territories in the north are fairly well advanced, and it is hoped to bring them in early in 1960.

The blueprint for each participating Provincial plan is contained, as mentioned earlier, in a formal agreement signed by both Federal and Provincial governments. This agreement is paralleled by enabling legislation in the Provincial legislatures and forms in effect a contract between the two levels of government. A list of the points that must be covered in each Provincial agreement is specified in the Federal act.

First, a schedule of hospitals which are to provide insured services is specified. These include general, chronic, and convalescent hospitals and such facilities as laboratories and radiological centers, but not mental and tuberculosis hospitals or nursing homes as such. It was felt that individual listing was simpler and more flexible than attempting to define broadly the type of "hospital and other facility" to be included. As well as the scheduled hospitals, which form the majority, there are also listed a small number of contract hospitals (usually company hospitals in outlying areas) which are reimbursed for insured services at an agreed flat rate per capita rather than according to actual expenses. Psychiatric wards in general hospitals can be included, although separate facilities for mental care can not.

The Provincial agreement also lists other acts of Provincial and Federal legislatures which already entitle certain groups of persons to hospital benefits. These include legislation regarding workmen's compensation and benefits for veterans, servicemen, and Royal Canadian Mounted Police. Benefits provided under these special acts are not paid for again by the Provincial hospital insurance plan, although of course the necessary services may be given in Provincial hospitals.

The "scheme for administration" is an integral part of the written Provincial agreement. This includes details of the appointment and duties and responsibilities of the Provincial hospital authority; arrangements for licensing and inspecting hospitals; method of reimbursing hospitals for insured services; and plans for future development of health services in the Province.

Finally, the agreement specifies the range of drugs and biologicals to be supplied in hospitals as part of insured hospital service.

The Federal act and the written agreements with the Provincial governments setting up the framework of the national hospital insurance program in Canada allow considerable individuality in Provincial plans.

Differences in Provincial Plans

The method of financing the Provincial share of the cost of the plan is one point of difference. Four of the eight Provinces with plans now in operation (Ontario, Manitoba, Saskatchewan, and New Brunswick) have chosen to levy premiums on the insured population. Annual rates are $25.20 for single persons and $50.40 for families in Ontario, $24.60 and $49.20 in Manitoba, $17.50 and $35 in Saskatchewan, and $24.60 and $49.20 in New Brunswick (*5*). The other Provinces finance their share from general revenue or special sales taxes.

On the issue of compulsory versus voluntary coverage, clearly only "premium Provinces" can allow residents a choice of whether to contribute or not. The Ontario plan makes coverage compulsory for employees working in establishments of more than 15 persons, but for others it is optional, with voluntary registration and payment of premium. This arrangement was adopted not out of deference to the principle of voluntarism, but rather because of the difficulty in collecting compulsory contributions among small groups and the self-employed. Alternatives to the Provincial plan in the form of nonprofit or commercial insurance for basic hospitalization are now forbidden, so the effective choice for Ontarians is Provincial hospital insurance or no hospital insurance. Ninety-three percent of the population of Ontario is now in fact covered by the Provincial plan. New Brunswick and Prince Edward Island have adopted similar arrangements, but in all other participating Provinces coverage is in effect compulsory for all residents.

Deterrent charges, or "hesitation fees," have been adopted by two Provinces of the eight. British Columbia, whose plan dates from 1949, continues to charge $1 per day for hospitalization. Alberta levies a variable charge of from $1.50 to $2.00 per day depending upon the size of hospital, and a flat $1 per day (up to a maximum of $30) for newborns. These charges are expected to meet only a small part of total cost—about 6 percent in British Columbia and 12 percent in Alberta (*4*)—and their main intent is to control utilization.

Each Province must provide at least the inpatient services specified in the act. Most of them, for the present, limit services insured under the Provincial plan to this level, but there is nothing to prevent a Province from providing a wider range of services if it wants to pay for them itself. Thus, Ontario and in effect Saskatchewan as well have chosen to include care in mental and tuberculosis hospitals as part of insured benefits, the additional costs being met entirely from Provincial revenues. Whether as a part of insured hospital benefits or under other public programs, the Provinces of Canada, like the States in the United States, subsidize care in tuberculosis and mental hospitals.

Insured outpatient services, optional to the Provinces, vary across the country. Newfoundland, for example, provides outpatient laboratory and radiological services, encephalograms, cardiograms, and basal metabolism estimates, all together with necessary interpretations, radiotherapy and physiotherapy treatment for ambulatory patients, and other outpatient care provided by salaried hospital staff. At the opposite end of the scale, Alberta provides no outpatient services at all. All other participating Provinces include at least emergency outpatient service within 24 hours of an accident (48 hours in Nova Scotia). The small range of outpatient benefits in several Provinces is regarded as temporary, to be liberalized as the plan gets underway. Manitoba has already (in February 1959) extended its coverage of outpatient benefits in the interest of reducing pressure on inpatient facilities, and others may follow suit shortly.

Limitations on drugs that may be prescribed as part of insured hospital service also vary. Most Provinces have left the matter to be decided according to accepted medical practice, with some provision for medical review. Saskatchewan and British Columbia, possibly through longer experience, have listed certain exclusions. Saskatchewan, for example, excludes amino acids, injected antibiotics other than penicillin, and streptomycin; and British

Columbia, cortisone and ACTH. Saskatchewan maintains an approved list of new drugs. All Provinces exclude preparations sold under the Proprietary or Patent Medicines Act. Excluded drugs may, of course, be used in hospitals, but the patient must pay for them.

The Provinces are required to name an authority responsible for the operation of the Provincial plan. In three of them, Saskatchewan, Alberta, and Newfoundland, a division of the Provincial health department has been given administrative responsibility. These three all had hospital plans of greater or lesser scope under their departments of health before the new program commenced. British Columbia, which also had an earlier plan, has retained its separate Hospital Insurance Service which reports through a commissioner directly to the Provincial minister of health, and Manitoba has adopted a similar arrangement. Ontario, Nova Scotia, and New Brunswick have set up independent hospital commissions with membership representative of medical, hospital, labor, and other fields. Prince Edward Island is expected to do likewise.

Hospital Costs

Individual hospitals are reimbursed in full by their Provincial hospital authorities for the operating costs incurred in providing insured services under the Provincial plan. The detailed procedure for making these payments varies among the Provinces. Most Provinces make monthly or semimonthly advances to the hospitals according to a per diem rate established from the annual budget for each hospital, with necessary adjustments being made at the year's end when the final accounting of actual costs is completed. Ontario tried a dry run in 1958, before payments were actually commenced, to familiarize all concerned with this procedure. Some Provinces differentiate fixed and variable hospital costs, paying the hospital a flat monthly or semimonthly sum plus an amount varying with the hospital's actual patient load.

All scheduled hospitals in each participating Province are required to render uniform accounts of their costs, which are ultimately audited at both Provincial and Federal levels. Items that seem excessive or unnecessary in relation to costs in other hospitals may be disallowed, although close cooperation between the various accounting units augurs a minimum amount of friction in this respect. A useful byproduct of this system will be the further standardization of hospital accounting procedures across Canada—already made reasonably uniform by use of the Canadian Hospital Accounting Manual—which will eventually yield much valuable comparative information on hospital costs.

The calculation of what the allowable cost actually is in each hospital is naturally a complicated accounting process which cannot be fully described here. Some general features will be described, however, because they are crucial to the financial relationship between hospitals, Provincial hospital authorities, and the Federal Government.

Total hospital costs include all normal operating expenses of the hospital such as wages and salaries, surgical supplies, food, linen, purchases of furniture and technical equipment (other than ambulances), and administration. Volunteer labor, paid nominal or no wages, may be counted as if it were paid in full at going rates, an important provision particularly for hospitals run by religious orders.

The allowable hospital cost, however, does not include interest and carrying charges on the hospital's outstanding debt or depreciation on hospital plant, buildings, and land. This important exclusion in effect restricts the program to current hospital expenses, leaving capital costs to be financed by the hospital itself or the Provincial government as before. Hospital deficits, therefore, are not necessarily wiped out, and the program offers no direct assistance with the costs of construction or hospital expansion.

This exclusion of capital costs is the principal point of controversy in Canada over the act. Why was it decided to do this? Primarily, because no equitable formula could be devised that would include capital costs without unduly favoring some hospitals and Provinces at the expense of others. The amount of outstanding hospital debt and the degree of assistance given hospitals by their Provincial governments differ widely across Canada. Some Provinces, British Columbia, for exam-

ple, have Provincial arrangements which finance a large part of the hospital's capital cost, while others leave this to local communities, voluntary giving, or market fund raising. With such wide differences in capital costs, it was felt that a program designed primarily to insure hospital services should cover the operating costs only.

There were other subsidiary reasons for excluding capital costs. Sharing capital costs might involve the Federal Government in the difficult and controversial question of who owns the hospitals. It was desired to avoid any charge of nationalizing the hospital system. Also, it was felt that the continued need for local communities and their local and Provincial governments to finance the bulk of their capital costs themselves would insure maintenance of local interest and participation in hospital affairs, and would restrain the urge to build unnecessary facilities in small communities for reasons of local prestige rather than medical need.

Actually, hospitals are not left entirely unassisted with their capital costs. In hospitals employing volunteer labor, there will be considerable surplus on account of salaries which may be applied to meeting interest payments. Federal and Provincial aid with hospital financing under programs unconnected with the hospital insurance program continues. There is also in the act one provision designed to allow a certain amount of "free money" to hospitals to use as they wish. In general, the costs of services not insured by the Provincial plan are not reimbursed by the Provincial authority, since the patient is charged for them directly, but, of the amounts receivable (less bad debts) from patients for accommodation above ward level (representing the extra cost to the hospital of providing this preferred service), only one half must be deducted from total cost. This means, in effect, that the patient is charged for the additional cost of a private room, and then the hospital receives half this amount again from the Provincial authority. In hospitals which provide a considerable amount of nonward care, this provision will allow a substantial inflow of free funds which may be used for capital purposes.

There are also certain other minor hospital costs which must be deducted before the hospital's bill is sent to the Provincial authority. In general, all sales and recoveries fall into this category; this might include such items as private laundry, sale of drugs not provided under the Provincial plan, and sale of cigarettes and candy. The hospital cannot charge the Province for functions which are already paid for from other sources, for example, training of personnel to the extent that it is financed by health grants and other governmental programs. The costs of providing noninsured services, such as ambulance service, must likewise be excluded from the hospital's accounting of allowable cost.

Sharable Cost

The Province's hospital bill consists of the consolidated amounts paid to all scheduled hospitals in the Province, as described above, together with amounts paid to the contract hospitals for insured services they provide. Administrative costs of the Province's program, as distinct from administrative costs of individual hospitals, are not included, although some help may be made available for technical consultant and research services under the separate health grants program.

Several more adjustments have to be made, however, before the Province's "sharable cost," the cost which the Federal Government is to share in, is finally determined.

There will be in each Province some hospitalization provided to residents of other Provinces who are insured under the plan of their Provincial government. The costs of these services are reclaimed from the home Province of the persons concerned, and, therefore, must be deducted from the total Provincial cost. A similar deduction must be made for persons treated in Provincial hospitals whose care is already paid for under existing Federal and Provincial acts (for example, veterans and those receiving workmen's compensation), and for those whose care is claimable under the terms of any private liability insurance contract. The purpose of these provisions is to avoid duplication of payment for the same service. Added to the Province's hospital bill, however, are the corresponding amounts paid to other Provinces for care provided to insured persons and, incidentally,

to hospitals in the United States which treat visiting Canadians.

In the Provinces which charge deterrent fees for hospitalization, the amounts thus collected must be deducted from the total sharable cost, since they represent a part of hospital service paid for directly by the patient.

Once the total Provincial sharable cost has been determined, it is divided by the Provincial population for the per capita cost of hospital services in the Province. Twenty-five percent of this cost and of the Canadian per capita cost are added and then multiplied by the average number of insured persons reported at the end of each month in the year, to arrive at the Federal Government's contribution. In Provinces where the Provincial share is financed through sales tax or general revenue and coverage is universal, the number of insured persons equals the Province's population as estimated by the Dominion statistician. In the premium Provinces—particularly in Ontario, where coverage is partially optional—the insured population must be estimated from enrollment records. At the Federal level, the Canadian per capita cost, which includes all of Canada, is computed from the consolidated returns of all participating Provinces and estimates for the nonparticipating Provinces and Territories.

Hospital Care

The foregoing section should not be allowed to leave the impression that the main emphasis of the Canadian program is financial. All the costing details relate ultimately to the primary purpose of the act—furthering the provision of hospital service in the Provinces.

The actual quality of hospital care provided under the program must constitutionally remain a Provincial responsibility. There is no Federal intervention in hospital management, other than the requirement that Provinces arrange satisfactorily for supervision, licensing, and inspection of hospitals and "make such arrangements as are necessary to ensure that adequate standards are maintained in hospitals" (*3*).

However, institutions scheduled in the Provincial agreement as hospitals for purposes of cost sharing under the act must be approved by both Provincial and Federal authorities. It is clearly in the interests of the Provinces, as well as the institutions themselves, to have as many marginal hospitals upgraded to meet Federal requirements as possible. This is expected to be effective particularly in the area of long-term care establishments which might more strictly be defined as nursing homes, but which can provide the type of care for chronic and convalescent patients required by the act. Two such establishments in Peterborough, Ont., were licensed as chronic hospitals for purposes of the act, although most other nursing homes in the Provinces were found to lack the necessary facilities for consideration under the program at present. Parts of institutions that might otherwise be excluded, for example, tuberculosis sanitoriums, many of which now have unoccupied beds, have also been licensed for general care in some parts of Canada. The list of scheduled hospitals and facilities in each Provincial agreement is subject to frequent revision and amendment.

In all Provinces where hospital insurance programs have been newly established, the expected increase in demand for bed space has materialized to some degree. Figures are not as yet available, but nowhere has the shortage of hospital space amounted to a crisis. A part of the increase is expected to be temporary, caused by persons who postponed treatment to take advantage of the new insurance, especially in Provinces such as Ontario where details of the plan were publicized for many months before the plan became effective.

The Ontario Medical Association and others have organized medical staff committees to review admissions and discharges. Some Provinces have had to embark upon an expansion of hospital facilities in order to provide the contracted services. Nova Scotia, for example, had an estimated shortage of 2,000 beds at the time the program came into effect, but with aid from an expanded health grants program has already made up 1,300 of this deficiency. Each Provincial agreement is required to outline the Province's plan for organized expansion of facilities in the future, an incentive to the orderly development of Provincial hospital service.

The Health Field

An account of the way in which the new hospital insurance program has fitted into the

Canadian health picture would not be complete without mention of how it affects other Federal health programs and voluntary health insurance.

The health grants program, inaugurated in 1948, is the other major Federal health program. It provides Federal funds and technical assistance to the Provinces for specified health projects and has expanded continuously since its inception (*6*). The purposes for which the grants are made, together with amounts appropriated for all Provinces in 1959 (*7*), are:

Purpose	*Amount (in millions)*
General public health	$8.5
Tuberculosis control	4.2
Mental health	7.2
Venereal disease control	.5
Crippled children	.5
Training of health personnel	.5
Cancer control	3.6
Public health research	.5
Hospital construction	17.4
Laboratory and radiological services	8.5
Medical rehabilitation	1.0
Child and maternal health	2.0

These grants continue alongside the new hospital insurance program, except that some of them which cover services now a mandatory part of Provincial hospital insurance plans, for example, laboratory and radiological services, now go only to nonparticipating Provinces. Most of the grants are made for specified projects which are subject to Federal approval. In most cases, each Province is alloted a maximum amount under each category of health grant, with provision being made for transfer from one category to another of any surpluses left over.

The grants for hospital construction were doubled shortly before national hospital insurance came into effect and extended to cover costs of constructing interns' quarters and renovating old premises. They now provide approximately $2,000 Federal funds per bed, with a requirement for Provincial matching.

Some services optional to the Provinces under the hospital insurance program may alternatively be eligible for assistance under the health grants program. For example, several Provinces have chosen to continue rehabilitation programs under the terms of the health grants program because in this way the programs can be restricted to certain needy groups of beneficiaries; if these activities were included in the hospital insurance program, they would have to be universally available to all residents of the Province.

The medical profession in Canada endorsed the hospital insurance program, guided largely by favorable reports from its members in British Columbia and Saskatchewan who had worked under Provincial hospital insurance plans for some years. Hospitals appear to have reacted favorably. In Quebec, there is reported to be considerable pressure from hospitals for entry into the program, and it is expected that ultimately Quebec will join, making the program truly national in scope.

As might be expected, a radical change has been wrought upon the voluntary hospital insurance picture. At the end of 1957, before the program came into effect, about 7.7 million Canadians had some hospital insurance coverage under private or nonprofit plans. With allowance made for duplication, this accounted for about 52 percent of the population exclusive of Saskatchewan and British Columbia, where compulsory hospital insurance plans were already in effect (*8*). As of January 1, 1959, the date the Ontario and Nova Scotia plans came into operation, nearly 11 million persons, or 67 percent of the population, were eligible for benefits under the new national hospital insurance program. By the end of 1959, the only Canadians not eligible for benefits will be the 4.6 million who live in the nonparticipating Province of Quebec.

Private insurers and Blue Cross plans continue to write hospital insurance for service above ward level in most Provinces. In Ontario, indeed, the hospital commission has offered to collect premiums for private and nonprofit insurers to facilitate this extra coverage. The new pattern is not yet sufficiently established to know how many persons will purchase additional insurance, but, as an indication, in British Columbia in 1957, about 6.6 percent of the population was covered by voluntary hospital insurance for preferred accommodation in addition to basic Provincial coverage (*9*). Voluntary insurance for surgical and medical expense is, of course, unaffected.

Blue Cross, as such, has virtually disappeared in most of Canada. However, the disappearance may be more in name than in fact, because the personnel, records, and experience have in most cases been absorbed directly into the new Provincial hospital organizations. In Ontario, for example, the 500 employees of the old Ontario Hospital Association's voluntary plan have all been transferred to the new Ontario Hospital Commission and continue to perform the same function on a larger scale.

The new hospital insurance program has been called by one Federal official "the most significant development in the health field in Canadian history" (*4*). It clearly goes far toward meeting what Hon. J. Waldo Montieth, Minister of National Health and Welfare, termed "the obvious needs of Canadians for an orderly and economic means of obtaining basic hospital care" (*10*). Because of the close similarities between Canadian health needs and our own, the further development of this experiment will bear close watching from the United States.

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Grants for Extramural Research in Nursing

Ten new awards, totaling approximately $250,000, have been granted for extramural research in nursing by the Public Health Service, bringing to 73 the total of grants awarded under the nursing research grants program since its inception in 1955. Awards to persons outside the Service for studies on nursing and improvement of patient care, now amounting to $3 million, are administered by the Division of Nursing Resources in cooperation with the Division of General Medical Sciences of the National Institutes of Health.

The recent awards are for studies on cardiac and psychiatric nursing, nursing education (including improvement of research competence), and the educational and socioeconomic factors affecting nurses.